POC acceptable 1/28/2010

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS666HOS	A. BUILDING _____ B. WING _____ Tag S 138	C 12/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U M C OF SOUTHERN NEVADA	1800 WEST CHARLESTON BLVD LAS VEGAS, NV 89102

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S 000	Initial Comments This Statement of deficiencies was generated as the result of a Hospital Licensure Complaint Investigation conducted at your facility from 12/11/09 through 12/21/09 with off-site review from 12/21/09 through 12/31/09, and in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The census was 391 at the beginning of the survey and 55 patient records were reviewed. The following complaint was investigated: Complaint # NV24030 - Substantiated (See Tag 0138) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	S 000	RECEIVED JAN 14 2010 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	
S 138 SS=J	NAC 449.331 Emergency Services 1. A hospital shall develop and carry out policies and procedures to ensure that emergency services and medical care are provided in accordance with NRS 439B.410 and 42 C.F.R. § 489.24. This Regulation is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to	S 138	***How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice?*** Corrective actions will be accomplished through the following actions: Clinical Education Director to provide Triage Class inclusive of an overview of EMTALA Law. Education to be mandatory for: Quick Care Clinics, Emergency Department, and Labor/Delivery Registered Nurses. The identified departments are emergency patient patients of entry at UMC.	

receipt approved 1/29/10

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Kathleen Silver — TITLE: Chief Executive Officer — (X6) DATE: 1/14/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 138	Continued From page 1 complete a medical screening exam in a timely manner for 1 of 55 patients sampled (Patient #37). Reference: NRS 439B.410 "Hospital required to provide emergency services and care... 1...each hospital in this State has an obligation to provide emergency services and care, including care provided by physicians and nurses, and to admit a patient where appropriate, regardless of the financial status of the patient. 5 (a) 'Emergency services and care' means medical screening, examination and evaluation by a physician...to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition or active labor, within the capability of the hospital... (2) 'Emergency medical condition' means the presence of acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (I) Placing the health of the patient in serious jeopardy; (II) Serious impairment of bodily functions; or (III) Serious dysfunction of any bodily organ or part..." Findings include: Patient #37 1. Record Review (Quick Care visit) Review of the patient's record at the one of the	S 138	***Tag S 138 (Continued)*** ***How will facility identify others having the potential to be affected by the same deficient practice?*** Quick Cares, Labor & Delivery and Emergency Departments (Adult & Pediatrics) are the three points of entry for emergency patients at UMC. These points of patient entry were determined by members of the Throughput Committee. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?*** Measures are multi-factorial and measures include: 1) Staff observation at identified points of entry; 2) Staff interviews from identified areas to validate staff knowledge; 3) Monitor compliance to assure patient care meets intent of law. ***How will facility monitor its corrective action?*** Throughput Committee has been charged to monitor the above identified measures. ***Responsible Person(s) / Title:*** Director Clinical Education to create and provide education; Director Quick Care, Director ED, and Director Labor/Delivery to assure staff attend training. ***Date of Completion:*** February 15, 2010 **QUICK CARE SPECIFIC:** **1- *How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice?*** Quick Care staff & Physicians to standardize triage and assessment documentation tool with Emergency Department documentation tool. This Quick Care documentation tool will be faxed to Patient Placement Center, after the initial call and the chart will be immediately scanned into Chart One so that the ED can retrieve the information prior to the patient arrival.	

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S 138	Continued From page 2 hospital's "quick cares" indicated the following: - The patient presented on 11/30/09 at 5:25pm and the intake performed by an RN (registered nurse). - chief complaint was "BLQ (bilateral lower quadrant) abd (abdominal) pain vomit x2 (times 2) today middle LBP (lower back pain) - denies dysuria (negative) diarrhea" LMP (last menstrual period) was "x2 days ago.". - pain was assessed at intermediate frequency, on a level of 10 (out of a scale of 1-10) and the duration was for 2 days. - Vital signs noted BP (blood pressure):161/89, pulse:109, resp (respirations):24 and temp (temperature): 97.4 orally. - At 5:35pm "urine obtained" was noted and Rm#3. - At 5:40pm the physician initialed orders for a "UA" (urinalysis) and "urine pregnancy." At 5:45pm it was noted "not able to go-no urine obtained." - The physician documented "transfer to (name of facility) ER (emergency room) by POV (privately operated vehicle)... discharge rx: no, Condition at discharge: stable... diagnosis: Abdominal pain, Emergent, and MSE only (Medical Screening Exam)-no charge..." - The mode at discharge was ambulatory and the facility's name was documented. At 6pm the patient's signature was noted acknowledging instructions. - The physician's physical exam at 5:55pm noted basically the same with a review of systems and including "severe" pain of 10. - The certification transfer forms noted the patient's undated, unwitnessed signature, the physician's indication the patient was stabilized with the physician's dated and timed signature. The facility's ER contacted at 5:55pm and the	S 138	***Tag S 138 (Continued)*** ***How will facility identify others having the potential to be affected by the same deficient practice?*** The Quick Care patient population is the only patient population in which UMC can control and integrate patient care documentation to streamline process for our patients. The Quick Care patients are the largest percentage of patients transferred into the UMC Emergency Departments. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?*** Measurement review documentation of comprehensive patient care to be performed as peer review activity for appropriate Medical Staff Departments. ***How the facility will monitor its corrective actions?*** 100% review of documentation received from Quick Care for patients transferred to the UMC ED to determine if comprehensive and appropriate (ie., repeat physical exams and duplication of diagnostics in the ED will be minimized). ***Responsible Person(s) / Title:*** Medical Director Ambulatory Services & Medical Director Emergency Department. ***Date of Completion:*** March 1, 2010 **2- *How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice?*** For patients being sent from Quick Care to Emergency Department: Quick Care Admission Representatives to fax patient transfer paperwork and demographic information to Patient Placement Center (PPC) located on the main hospital campus. PPC staff will enter the patient information being transferred to UMC into the AS400 (main campus registration software), create patient	

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S 138	Continued From page 3 person accepting was documented as "charge nurse (illegible first or last name). Private Vehicle was circled and the physician's dated and timed signature was noted. There was no indication on the record the staff were aware of anybody accompanying the patient. The record indicated accompanied by "self." The patient was released with instructions to go to the ER ambulatory, stable, but in severe pain. - The documentation failed to include a written narrative of the physical exam and failed to indicate clearly who the individual at the ER was who accepted the patient and if a report was given to that person. Interview The following interviews were conducted regarding the Quick Care on 12/21/09. At approximately 8:30am, the COO (Chief Operating Officer) over the Quick Cares (QC) indicated the following: - The COO/QC gave an overall account that patients in general may mostly have low income so they will most times reject the ambulance out of fear of not being able to pay. Also, the ambulance, although directed to go to the facility's ER may elect on their own to take patients to a different hospital's ED (emergency department). - The COO/QC indicated the physician (who saw Patient#37) said that Patient #37 was tachycardic and someone wrote the wrong vital signs documented on the hospital's ER sheet. When asked whether a physician's narrative note regarding the exam and the diagnosis and plan, the COO/QC responded there was no narrative note from the physician although patients may be given documents from Urgent Care (Quick	S 138	Tag S 138 (Continued) labels; and create EmSTAT (ED Electronic Record). When patient arrives at UMC ED there will be no need to re-register the patient. ***How facility will identify others having the potential to be affected by the same deficient practice?*** In addition to the measures identified for the three points of entry for emergency patients referenced above isolated patient transfers will be prioritized. If patient volume determines intervention necessary, the process will be replicated. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?*** Measure time for patients sent from Quick Care: Time patient arrives at UMC ED to time patient seen by appropriate medical health care professional with a created patient care record. ***How the facility will monitor its corrective action?*** Management Analyst for Emergency Department will determine patient times before and after process modifications. This measurement activity is possible because of EmSTAT ED automated record system ***Responsible Person(s) / Title:*** Director Quick Care, Director Patient Placement Center and Director Emergency Department ***Date of Completion:*** February 1, 2010 3- ***How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice?*** Standardize triage methodology between Quick Care and Emergency Department. This standardization will limit patient triage to one triage process as opposed to two triage processes. Quick Care education required.	

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S 138	Continued From page 4 Care). - The COO/QC further added the system of documentation was not in communication with Quick Care and the facility's ER - "we don't have the same system so electronically, they don't communicate with each other...In this case, she (Patient #37) went with her boyfriend in the vehicle and someone was informed she was being sent as a courtesy call but it's hard to keep up with who in the ER receiving the call because not any one person is taking responsibility for that call. It's not a report per se, on the patient to the physician, we just call the ER to give them a heads-up..." - When asked, the COO/QC agreed it was not fair for a patient to have a medical screening exam at the QC, be referred to the ER and then have to wait in their waiting room for another medical screening. Regarding Patient #37 at the Quick Care on 11/30/09, the following were interviews of indirect and direct care staff on 12/21/09: - Interview at 9:10am revealed, the charge nurse stated the patient was on her way to the rest room to give a urine sample , had been placed in Room 1. "She (Patient #37) left a small amount of sample. She was overweight and tall, did not appear to be pregnant. Her affect seemed to be flat...didn't seem to be in any pain. She was erect in walking...walked slowly... (Patient #37) had a 10/10 for pain. The patient was a MSE (medical screening exam) and the chart was marked by the physician as emergent "so we did everything. Normally the MD (medical doctor) decides if they are emergent or urgent." - Interview at 9:30am , an LPN (licensed	S 138	***Tag S 138 (continued)*** ***How the facility will identify others having the potential to be affected by the same deficient practice?*** This is the only identified appropriate patient population identified for this strategy. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?*** Monitor number of patient transferred from Quick Care with appropriate triage assignment. ***How the facility will monitor its corrective actions?*** Measurement outcomes and analysis will be responsibility of the Throughput Committee. This Committee is multi-disciplinary, membership includes: Medical Staff, Nursing Staff, Hospital Administration, ED Leadership and Quality Control Leadership. ***Responsible Person(s) / Title:*** Director Quick Care and Director Emergency Department ***Date of Completion:*** March 1, 2010 **EMERGENCY DEPARTMENT SPECIFIC:** **1- *How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice?*** Emergency Department and Triage Areas to be staffed by Nurses and Physicians Only. ***How the facility will identify others having the potential to be affected by the same deficient practice?*** This is the only identified area affected by this action. ***What measures will be put into place or what systemic changes you will make to***	

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S 138	Continued From page 5 practical nurse) stated, "there's 2 people doing the intake. I may not see them (other nurse's patients). The only thing I can remember about this person (Patient#37) is that the doctor said 'what about the urine' and (name of other nurse) said that the urine was so bloody... I signed her out but I don't remember this lady...original copies of the certification to transfer forms and physical exam sheet and insurance information are sent in an envelope that says (name of facility), with the patient. I don't remember anything else and don't remember her. The only reason I remember anything is what (other nurse) was said about the bloody urine and the doctor responded 'that's OK I'm sending her to the ER at (name of the facility).'" - Interview at 10:00am by telephone interview, the triage nurse stated Patient #37 "came in by herself to the lobby with me back to triage...I asked her if she was pregnant or breast feeding and she said her symptoms were coming in with UTI-like (urinary tract infection - like) symptoms. She had a flat affect. No expression change...My role with that patient was I triaged her, asked her about her LMP (last menstrual period) but I just remember her flat affect. She really didn't say anything else I can remember. Maybe a flat affect is the way she responds to pain but that's all I can say about her. That's all I can remember about her." At 2:35pm a telephone interview with the QCMD revealed, the patient "went in the room presenting with abdominal pain was asked did she have any diarrhea, nausea vomiting, worsening and period information. On examination, she had no rebound or guarding but said she was hurting and it was intense and I told her she needed to have an ultrasound or CT	S 138	***Tag S 138 (continued)*** ***ensure that the deficient practice does not recur?*** Review staffing methodology and staffing patterns. ***How the facility will monitor its corrective actions?*** Same as above. ***Responsible Person(s)/Title:*** Throughput Committee, Director Emergency Department, Medical Director Emergency Department, and Hospital Leadership. ***Date of Completion:*** December 7, 2009 **2- *How corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice?*** Modify hands off communication between ED Nurses and Inpatient Nurses: EmSTAT (Electronic ED Record) summary of patient care will be printed and faxed to determine inpatient unit. Nurse to Nurse questions to be answered via telephone. This will allow ED Nurses to remain in their department and focus on ED patients. ***How the facility will identify others having the potential to be affected by the same deficient practice?*** The action will only be applicable for the Emergency Department. ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?*** 1) Survey inpatient Nurses to determine if faxed report meeting patient needs. 2) Monitor ED patient time in the department. ***How will facility monitor its corrective actions?*** 1) Staff interview; 2) Review adverse patient events to determine if hand off communication affected event.	

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S 138	Continued From page 6 scan. We tried to obtain urine but it wasn't enough urine. The patient was a big girl and not protuberant. I called over there (facility's ER) spoke to the charge nurse and she accepted the transfer. I offered the patient transfer via ambulance, and when they are stable, if they need cardiac monitor or hep (heparin) lock then they will need an ambulance and if they refuse they are asked to complete AMA (against medical advice) documents. The fiance and patient had paperwork to be turned over to the ER." Patients sent from QC present to the ER with his understanding that they will be seen for more diagnostics such as CT scan or ultrasound. He stated he wrote the name of the ER nurse down. The physician stated his understanding is that it is an MSE at Quick Care so it would not be expected that the patient would have to wait for another MSE in the ER. On 12/21/09 at 11:00am a telephone interview with Patient #37's fiance revealed, "When they called her back initially, I went to the nearby store. One of the doctors pressed her stomach. He was releasing her (Patient #37) to a higher (level of) care. He doesn't have the equipment for accurate diagnostics. He told us that we would be released to go to the ER. They (ER) knew we were coming..." On 12/21/09 at 2:00pm a telephone interview with Patient #37 revealed, "They asked for my urine. I couldn't urinate. He (the doctor) didn't say what he suspected was the problem. He asked did I have someone with me and I said I did and we went to (the facility ER) in the car. (QC) Staff gave me paperwork to give to (facility) ER. No they didn't offer any other form of transportation."	S 138	***Tag S 138 (continued)*** ***Responsible Person(s)/Title:*** Director of Emergency Department and Chief Nursing Officer. ***Date of Completion:*** February 1, 2010	

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S 138	Continued From page 7 2. Record Review (ER visit) The facility ER record for Patient #37 indicated the following: The face sheet indicated: - "admit date: 11/30/09 time 19:06 (7:06pm)" - "brought by: boyfriend" - "Nurse's notes admitting comp (complaint): QC (Quick Care) -LT (left) Lower Abd (Abdominal) Pain/Vomiting" The triage sheet indicated: - "Complaint: Qc/lt lower abd. pain/vomiting" - "Arrival Date/Time: 1835 (6:35pm) 11/30/09" -"Arrived by: Private Vehicle" - "Mobility:Ambulatory" - "Accompanied By: None" - "Acuity: 3 - Urgent" -"Complaint Code: Abdominal/Gastrointestinal" -"Treatment PTA (prior to arrival): None" - "LMP Date: 11/28/09" The triage nurse was Emp #4 At the bottom of the triage sheet Vital signs were initialed and recorded as follows: - Emp #2's initials 18:38 (6:38pm) Temp (temperature) 98.2 O (oral) Blood Pressure (BP) 153/87108 automatic, sitting, left arm Pulse 102 Resp 22 - Emp #1's initials 21:05 (9:05pm) Temp 99 BP 169/91/119 Pulse 55 Resp 20 - Emp #3's initials 21:06 (9:06pm) Temp 97.4 BP 109/67/79 Pulse 73 Resp 16 The pain was recorded as follows (on a scale of 1 as the lowest level of pain and 10 being the highest level of pain):	S 138	Accepted Approved 1/28/10	

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S 138	Continued From page 8 - 21:04 (9:04pm) 10/10 (10 out of 10) - 21:05 (9:05pm) 10/10 -21:42 (9:42pm) 10/10 On the assessment sheet the following was documented: At 21:01 (9:01pm) Emp #3 indicated, "Reassessment: Patient remains in waiting/triage, Vital signs rechecked, Patient complains of worsening symptoms Note: pt (patient) states the pain in worse" At 21:40 (9:40pm) Emp#4 (triage nurse) documented "initial triage info," among other data that the patient's chief complaint was "Qc (quick care) /lt lower abd. pain/vomiting" with the acuity of 3 - Urgent. The notes continued at 21:42 that Patient #37 had left abdominal constant sharp pain, "converses easily in full sentences, and that pain alleviating factors were a "calm, quiet environment, caregiver comfort/reassurance, ED (emergency department) staff comfort/reassurance, positioning" At 22:28 (10:28pm) Emp #4 Reassessment notes documented the patient was still in waiting/triage "Note: still waiting for available ER bed/ (name) charge nurse notified. family wants to speak to Charge RN." At 22:39 (10:39pm) Emp #4 Reassessment notes documented "Reassessment: Wait explained to patient, Patient remains in waiting/triage Note: Pt's family gets loud, approached front desk and has explained calmly to pt re (regarding): waiting for availability of ER bed. (name) CN (charge nurse) notified, wants to speak to charge nurse"	S 138		

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S 138	Continued From page 9 From 21:04-21:05 (9:40-9:05pm) Emp#1 documented pain severity of 10/10 for Patient #37 and more vital signs with a blood pressure taken using a neonatal cuff (inappropriate for an adult). At 21:42 (9:42pm) blood work was ordered for a complete blood count (CBC), Lipase, Liver Panel, Metabolic Panel -Basic 7, and Pregnancy Serum and documented by Emp #4. At 23:22 (11:22pm) Emp #5 documented an additional lab test "HCG Quant Serum" (Human Choriogonadotropin quantitative serum). At 23:31(11:31pm) Emp #6 documented, "Note: Patient's family disruptive and yelling at staff, family warned to calm down or he will be asked to leave the ED. security here." At 00:06 (12:06am) Emp #6 documented, "Note: patient paged several times.... noted by security leaving building. Chart will be placed inactive." The lab results for the CBC documented at 22:52 (10:52pm) showed an elevated white blood cell count and other abnormal results. The lab results documented results at 23:19(11:19pm) the pregnancy serum test revealed "Pregnancy Test, Positive." Subsequent to the above lab test, Emp #5 documented additional quantitative test to be done. There was no documented evidence Patient #37 or the physician was notified of the results of the abnormal CBC or the positive pregnancy test. Per the times documented in the notes Patient #37 was still present in the facility.	S 138		

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S 138	Continued From page 10 Despite documentation Patient #37 was in severe pain there were no other options documented other than the patient needed to wait in the waiting room and that there was no room in the back for the patient. No other tests were done such as the CT or ultrasound which was expressed in the interview with the QCMD. There was no documentation the nursing staff alerted any physician or higher nursing administration managers of the need to get the patient seen by a physician to complete the screening already started by Quick Care and to diagnose and treat the patient. The facility failed to accomplish a medical screening exam in which they were already aware as documented was initially started at the Quick Care. Interview ER MD Director on 12/15/09 at 10:30am indicated he saw several areas where "we failed." The CNA (certified nursing assistant) shouldn't have taken upon extra things to do - just do vital signs. If the record says QC they came from Quick Care and it clearly says it on the logs if they came from Quick Care, and they should have asked for her QC paperwork - I don't think they asked for it...she would have gone all the way through in ER if QC documents (were obtained)...they forgot customer service..." ERMD#1 was interviewed on 12/15/09 at 11:10am. He explained that he was the doctor in charge of OB/GYN cases. He stated, "Nobody came to me with any complaint. I know I was the OB/GYN on the west side at the time. We saw	S 138		

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S 138	Continued From page 11 several OB/GYNs ...if someone is there in abd. pain, labs - CBC, LFTs, Lipase, Chem 7, Serum pregnancy test is ordered and they put the name of the doctor in charge. I answer the phone. If we know she was 25 weeks she would have been seen straight back. We saw a lot of ladies who complained of abd pain, bleeding. I wasn't informed of her (Patient #37)." There were a number of things ERMD#1 indicated Patient #37 would have been screened : ultrasound versus going straight up to L&D (labor and delivery) but to his recollection he was not informed of her (Patient #37) case on the night she initially presented to the ER. ERMD#2 was interviewed on 12/15/09 at 1:15pm. He explained how the ER is separated into the east side and west side. "I take treatment calls, go to codes and resuscitations. If it's major events that take place I may know about it. I was walking by the radio when pt (Patient #37) came back (returned after leaving the ER) and I inquired as to what was going on and told them to go to L&D. I was on the east side. I never wound up seeing the pt." On 12/15/09, Employees #1 through #6 declined request to be interviewed through their employee union representative. All 6 employees had reportedly been on suspension pending possible termination. On 12/15/09 at 11:00am, Security Officer #1 (SO #1) stated, that night (on 11/30/09), "We had about 120 patients. As I was exiting to assist (another patient) at about 9 pm, (Employee #1(Emp #1)) said this fiance is threatening staff and specifically said I needed to talk to him. Up to this time I didn't hear anything out of the ordinary but I did step away for awhile. He did	S 138		

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S 138	Continued From page 12 not state what he meant by 'threatening staff.' SO #1 stated Emp #1 initiated the discussion after escorting the fiance near the exit door, and directed the fiance to not use profanity, and the fiance said he didn't, and that was that, went back to his seat. SO #1 continued to observe the fiance, but saw and heard nothing from him." SO #1 then drew a diagram of how close his desk was to the people in the waiting room and indicated how he would have heard a commotion if it occurred, but heard nothing before the incident with Emp #1 nor after the fiance went back to his seat. On 12/15/09 at 2:35pm, SO #2 who was posted at the security desk on 11/30/09 from 6pm -8pm stated, "There was a white female, never spoke with an African American female and don't remember her speaking to any of the staff. We had a lot of people who came to the security desk. I remembered seeing her but never had a conversation or heard of her fiance/family speaking to staff." On 12/17/09 at 2:00pm, SO#3 stated "I observed -worked grave shift, took over shift at 10:15. We usually pass information from other officer. Every 2 hours we usually change watch (at the security desk in the ER). Around 10:15pm there was a lot of people anxious. SO #2 said there was a gentleman waiting for a charge nurse to come out and talk to him. Our eye gaze met-they tend to become anxious. About 1 hr or 45 minutes later, the fiance went to the desk spoke to (Emp #3) and called the nurse politely. I saw he approached (Emp #3) and she nods her head. Calls one of the nurses. Two nurses come and one (Emp #6) say answers 'if you keep interrupting I'll call security' I never heard any profane language. He just went back to his	S 138		

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S 138	Continued From page 13 seat. A little bit later, 30 - 40 minutes around 2400 or 0015, he calls (Emp # 3) and asks nurse when (Patient #37) is going to be seen. Patient #37 didn't go up to complain. (Emp #6) comes at the corner of the desk and lifts her finger and said to him, 'I am going to have to security escort you out'..." "I felt the fiance was asking legitimate questions. I felt there were also other anxious persons waiting in the room. I explained that people are see in accordance with the severity and I was explaining what I thought the nurse should have explained. He asked how many doctors were back there and when will she be seen, she's been here a long time. People ask this all the time in the ER. Trying to ease the situation I explained. He puckered his lips and I was helping another person to direct how to go to loved one's area. When I came back and noticed they (Patient #37 and fiance) were gone. She (Patient #37) was standing at the stairwell (by the parking garage) and they never asked for help. I figured that's where the visitors were parked. I concluded they were leaving and to come back later and then I heard they came back with Fire and Rescue. Their behavior was no different than anybody else's behavior. He was asking legitimate, good questions. (Emp #3) was acting polite answering his questions. (Emp #6), the way she twirled her finger - she never came to the desk to say he did anything untoward and I thought I was the mediator. I told my supervisor I thought he might get a complaint from nursing that I didn't eject (the fiance). I saw no reason to...I am glad I didn't." On 12/21/09 at 11:00am, Patient #37's fiance indicated at the ER, "nobody ever looked at the paperwork from QC. Two people knew we were	S 138		

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S 138	Continued From page 14 coming from QC. We tried to give them the paperwork at the registration. We went to the triage nurse and told them we came from QC. We (Patient #37) were waiting in pain. I went to one of the nurses and I was in no way being belligerent but I wanted them to know how long she was waiting and about the pain. They had attitudes at that night and they were acting antsy as if there was the last 3 minutes of the shift..." "(Employee #1) in my opinion embarrassed my girlfriend. He tried to get things in order and would ask 'how are you feeling right now,' and I said, she threw up. He said, 'do you feel like you're about to die and do you feel like you're in pain and how long have you been feeling that way... then you can wait longer...' he was talking about her so loudly everybody can hear. He called me outside and he told the security guard he needed to talk to me...(Employee #1) said, 'if you want to make a complaint you can talk to my boss."' "Later on that night (after the patient returned from her home in the ambulance to the ER) my mom walked back to him (Employee #1) and asked him how could he sleep at night knowing what had happened and asked to speak to his boss, and he said, 'OK well if you want to speak to my boss, I'll get my boss.' He never did come back with his boss." On 12/21/09 at 2:00pm, Patient #37 stated, "The nurse that checks BP asked what was going on - and I said, pain in my stomach and back, and I was told, 'Go have a seat.' A lady (staff) put all my stuff in system then asked me about pain scale between 1-10 and I said it was a 10..." "(Employee #1) came in and asked what type of	S 138		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 138	Continued From page 15 pain, he asked if I feel like I was about to die, and I said yes and he asked how long and I said for 2 days and he said , then you can wait another 35-40 minutes. I was trying to give the paperwork (QC documents) to them, no one would take it. They called me back and took three things of blood from me. I was sitting in pain, going back and forth to the desk and bathroom. I felt like I wasn't getting anywhere. They said they didn't have any room in the back. Finally left because I didn't think I was going to be seen. I never thought I was pregnant. A lady(staff) asked me if I thought I was pregnant and I told her it was a possibility. I was having unprotected sex so I knew it was possible." "I went to (other facility ER) after, and they wanted me to fill out paperwork and then my boyfriend told them about (previous facility ER). I couldn't fill out paperwork. I was in too much pain. They said, if you didn't get seen at (previous facility ER), what makes you think you are going to be seen here?... We left and went to a 7/11, took some pain medication and threw up, went home took a shower, still in pain, went to the bathroom and water broke and I looked down and saw feet came out..." "I am having flashbacks now. I was shocked because I didn't know I was pregnant and then having to see the baby's feet and then finding out I was pregnant and then the baby died. I was very shocked. I am having a hard time going to work now without thinking about it..." Patient #41 On 12/30/09 at 2pm, during a telephone interview Patient #41 revealed (regarding Patient #37),	S 138		

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S 138	Continued From page 16 - "Yes, I remember her and her boyfriend. They came in after I did. She was in pain. I saw her when she went to triage staff. She was sitting right in front of us. " - "As the hours went on and on, she was in more distress. My son said something and the charge nurse said 'If you guys don't quit you won't get any help'." When asked who the charge nurse was, she verified he was a man and his name describing Emp #1. - "Her boyfriend would go up to get help. When (Emp #1) would leave the room we all would go up to ask the other staff to get help for her (Patient # 37), because (Emp #1) said if she was in pain for 2 days, she can wait another 45 minutes. He told her that. He went around asking everybody in front of everybody else their problems, that's a violation of our privacy." - "Her boyfriend never said anything abusive. He was scared for (Patient #37). He said 'she needs help now.' (Emp #1) told him to have a seat. Whenever he (Emp #1) left we went up to the desk to ask for help for her (Patient #37). The boyfriend said 'How much longer does she have to wait?'" - "We were thinking she was pregnant and in labor, (we were) timing contractions. They (staff) asked her if she was in labor and they took her vital signs but she didn't know." - "It was not busy. There were several homeless people and there were empty seats in the waiting room. There was no standing room only. It was busy at first but it cleared up. I had to wait 8 hours and I had chest pain." - "I will never go back there again. I didn't have insurance so I thought that's where I was supposed to go. I know now that I can go to any ER if I don't have insurance. I don't want this to happen to anybody else."	S 138		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 138	Continued From page 17 3. Record Review (Paramedic Notes, Patient # 37 Hospital Admission Record, Pt #37 Baby Record) Paramedic Notes - The North Las Vegas Fire and Rescue responded to a call to Patient #37's residence and documented at 0051 (12:51 am) on 12/1/09, "Female found A/Ox4 (alert and oriented to person, place, time...) supine on floor with two legs and half a torso presenting from vagina. Pt (patient) pushed and baby delivered in cardiac arrest...Pt delivered placenta along with baby... no uncontrolled bleeding... transferred to (facility) Land D RN (labor and delivery registered nurse)." Patient #37 Hospital Admission Record - The facility's Labor and Delivery Summary dated 12/1/09 noted the onset of labor was on 11/30/09 at 1600 (4pm) and admitted to the hospital on 12/1/09 at 0140 (1:40am). Remarks and Comments included "Infant delivered in the field. Time of delivery by paramedic/pt. Infant was brought to NICU (neonatal intensive care unit) about 45 mins (minutes) from delivery (approximately 01:45 (1:45am))" The obstetrical resident's notes co-signed by the physician documented, "12/1/09 0200 (2:00am) Patient had rapid delivery in the field. Patient had pain starting Sunday (11/29/09) that she thought was abdominal in nature. Pain worse on Monday (11/30/09). Had vaginal bleeding on Monday. Blood clots that brought her to hospital. Reports "sharp pain every 2-3 mins" with bleeding. Was reportedly frustrated because she wasn't seen in ED for vaginal bleeding + (and) abd pain, and then left @ (at) midnight. At 1:30am delivered at home. Did not know she	S 138		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 138	Continued From page 18 was pregnant... This was a supposed breech delivery of approx (approximately 25 wk (weeks) old..." Pt #37 Baby Record The neonatologist's notes documented "12/1/09 02:15 (2:15pm) Infant was brought to the NICU by paramedics about 45 mins from birth. Infant was being given positive pressure ventilation with chest compressions. Infant with no heart rate, no spontaneous movement, no spontaneous breathing. Infant was noted to be cold. No temperature registering on the thermometer. No vital signs registering on the monitor. Positive pressure ventilation given with no response. Infant with bruising/ecchymosis on all parts of the body especially on both lower extremities... Apgar @45 mins: (0 for all signs of life) BW (birth weight) of 625 g (grams)." The typed summary of the same neonatologist's notes clarified, "There was an intraosseous line noted on the left lower extremity. Dark colored/chocolate brown blood noted to be oozing from the left wrist. Examination estimated the infant to be 23-24 weeks gestation...Cause of Death: Extreme Prematurity. Time of death: 01:45 (1:45am) (12/1/09), Dead on arrival." Document Review The following were written signed statements from 4 of the 6 employees previously designated who also refused to be interviewed, but were filed with the facility: Statement by Emp #1 "I was working in Amb. Pod 11/30/09 7p-3a. I was asked by charge RN to go to triage due to triage staff needing help...she (triage nurse)	S 138		

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S 138	Continued From page 19 asked me to help with vitals, talking to patients about the wait and CNA duties in triage. I then spoke with patient and family members about the wait, how triage works and answering any questions about the ER that I could...I then finish role call asked if any patients were ok. Several patients respond that they were very sick it was very busy. I believe we had 7 patients in orange cat. It was loud. I then turned and asked (Patient #37) how she stated she was in pain. I asked her to please be patient. She and her loved one became angry. I informed them that they would be seen as soon as possible. Emp #3 did revital the patient... The patient male family member began to curse at me , even threatening me "I will kick your ---" I then informed patient that making threats against staff was not appropriate. I even let public safety (Emp #1) know that patient loved one was threatening me. Public safety and I did talk to patient (fiance?) about threats and how it wasn't appropriate. Several things were going on at once. The patients in orange (emergent) needed to be re-vitaled. The room was loud. Patient male family member continued to be angry. he then came to me and ask me about if we could get a sample of her urine. I then gave him a urine cup. She voided it was cloudy bright red. I then put on triage B desk with a label. I was then asked to go back to the ER to float... The patient and male family member continued to be angry. Emp #3 was made aware. RN was informed about patient family behavior. On or around 0100 (1am) I was in the medical Pod. A telemetry call did come in (ERMD#1) did answer a call and directed the parm (Paramedic) which way to go about a lady that delivered. About 4:30am I was outside and the (Patient	S 138		

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S 138	Continued From page 20 #37) male family member and mother did approach me and ask me my name. I did give them my name and the mother told me, 'I just want to see your face. I want you to know that my daughter's baby died tonight because you did not give her care. I just want to know how you are going to sleep knowing that.' I then explained to patient family that she should talk with my charge nurse about her family member. I then informed Charge RN that patient mother and male family member was in front of ER and the comments she made to me. signed (Emp#1)." Statement by Emp #4 "11/30/09 Initial contact made with this patient (Patient #37) when called for triage around 2135 (9:35pm) - Triage obtained from patient, ambulatory with steady gait when received, a (alert) and oriented - airway intact - breathing non-labored - good skin color warm and dry - latest V.S. HR (vital signs heart rate) = 70's afebrile - Chief cpt (complaint) of (left) lower quadrant abdominal pain x 2 days vomited x1 in the morning, no further N/V (nausea/vomiting) presented. - denied pregnancy, was denied any bleeding, no vaginal bleeding presented at the time of triage process. - LMP 2 days 11/28/09. - No QC (quick care) paperworks received from patient and no other pertinent information received from her No other complaints made. - patient has been cooperative as I go through triage process, family with patient standing behind her.	S 138		

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LAS VEGAS, NEVADA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS666HOS	A. BUILDING _____ B. WING _____	C 12/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U M C OF SOUTHERN NEVADA	1800 WEST CHARLESTON BLVD LAS VEGAS, NV 89102

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S 138	Continued From page 21 - Asked about pain-has started 2 days ago on left lower abdomen area, getting more constant 10/10 sharp at this time, converses easily in full sentences. - Concerned with patient's pain status (same with other patients in pain waiting in ER) I have then informed (name of a charge nurse) re: situation, no ER bed available, no orders received from Charge nurse and left with no options, explained to patient and family has to go back in ER waiting area for now. - Emp #5 RN assigned in triage to place patient was informed of this patient and efforts initiated. labs ordered per GI (gastrointestinal) protocol. NPO (nothing by mouth) patient instructed not to drink or eat while waiting. ED process has been explained to patient/family. - Around 2228 (10:28pm), seen patient in chair, remains in ER waiting area, no distress. Family wants to speak to nurse above me. This referred to Charge Nurse after I explained waiting bed. Charge Nurse was informed again and states will talk to him. - 2239 (10:39pm), as I called for another patient to triage, seen patient remain sitting in chair ER and family at front desk loud. Charge Nurse has again been notified. - Around 2300 (11pm), called Charge Nurse - hasn't had a chance to talk to family. Called assistant manager and informed. - No new complaints was presented to me by patient or family of by CNA at front desk at this point. Addendum: I have noticed that this patient's family has been disrupting the triage process. Patient has interrupted 2-3x when I called for other patients waiting patiently to be triaged." Statement by Emp #3 "- Patient stated in a lot of pain wanted to know	S 138		

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S 138	Continued From page 22 how long it would be before patient would be seen by a doctor. - I explained to male friend that staff is working on opening up ED beds and as soon as there is an available bed in area that patient needs to go we will place patient. - Patient crying stating pain was worse and could not take pain. - Patient companion came up complaining and asking why others were called before her but not as sick - attempted to explain to male that people were called for blood work , etc. He walked away mumbling this is (curse word). - A little while later (Emp #1) did call and explained in his own words ED waiting process to whole waiting area. Male companion made statements to (Emp #1) after a couple of attempts to talk to male, (Emp #1) ask Public Safety officer to ask visitor to calm down. Patient companion talked to Public Safety Officers and seated back in waiting area. At about 2100 (9:21pm) called patient to desk to re-vital. Patient's visitor asked again "How long is it before patient is seen." I explained to patient and visitor again the waiting process. Patient and male visitor verbalized understanding thanked me for being nice and took a seat in waiting area. - Patient's visitor began to get more upset when other names being called, visitor came back to desk yelling saying he wanted his girlfriend to be seen now and continued to walk closer to me yelling making myself and others feel uncomfortable. - (Emp #6) RN asked patient to step in triage door to talk to her visitor, stated, 'No I'm not going to take her to be seen now." Visitor asked to calm down and both left." Statement by Emp #6	S 138		

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S 138	Continued From page 23 "2328 I was called to the triage area by (Emp #3) CNA to aid her with a patient's family member who was becoming disruptive. - (Emp #3) explained who the patient was and I noted it was the same case I was working on for placement. This patient was to go to OB as soon as the current patient was discharged and the room was cleaned. - I went out to the triage waiting room to bring the patient and the family into the triage B area . I called them explain the progression of their wait. The male family member confronted me as I exited the triage door. he refused to come into triage B area and demanded the patient be taken to an exam room immediately. His demands continued as I made several attempts to calm hi down and enter the triage B area. All the while this patient was yelling angrily at me the same time I was talking. - Finally after a few more attempts to speak I referred the family to security and assured the patient and family the charge nurse would talk to them soon. - At approximately 2355 I called the patient to transport her to a room and there was no response. Security told the CNA 'they left'." No written statements were submitted from Emp #2 and #4. The facility policy entitled Screening, Stabilization, and Transfer of Individuals With Emergency Medical Condition #I-6.7 Approval Date 3/17/09 "Definition B. "Emergency Medical Condition" means: 1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain...) such that the absence of immediate medical attention could reasonably expected to result in either: Placing the health of	S 138		

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S 138	Continued From page 24 the individual(or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy..." "Medical Screening Examination" - means the screening process required to determine with reasonable clinical confidence whether an Emergent Medical Condition does or does not exist." "Procedure: A. Medical Screening Exam. 1. The Hospital shall provide a MSE for every person who comes to the emergency department and seeks medical treatment or on whose behalf such a request is made, and shall also provide such an examination for every person who comes to another area of the Hospital Campus to seek treatment for a potential Emergency Medical Condition." The facility policy Emergency Policies and Procedures: Triage: Adult Emergency Patients#20.03 Approval date 12/13/2009 indicated: "Triage does not constitute a Medical Screening Examination (MSE) as required by EMTALA." The following were the specified acuity levels and color code as referenced in one of the interviews above: Triage Acuity Levels : Level 1: Resuscitation (Red Code) Level 2: Emergent (Orange Code) Level 3: Urgent (Yellow Code) Level 4: Less Urgent (Green Code) Level 5: non-Urgent: (Blue Code) Interview	S 138		

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S 138	Continued From page 25 On 12/16/09 at approximately 9:45am, the ER nurse director indicated there were 2 desk functions in the waiting room. "A person who is an RN (registered nurse) takes the initial information from the patient signing in, then takes the patient's vital signs and then there is the next person who does rapid registration and who takes more information (demographics) from the patient including routinely asking for ID (identification) and insurance information to expedite information collection and have the patient/significant other sign consents for treatment and they get an arm band. The patient's record will then have that information on the chart." Several interviews on 12/17/09 and again on 12/21/09 with the ER nurse director revealed an awareness of their growing census in the ER over recently with some measures on a quicker screening process, chairs placed outside the exam rooms to get the patients closer to treatment and foster closer monitoring. It was indicated with a an illustrative chart that the evening Patient #37 presented over a long span of time , there were no available seats or a bed to place Patient #37 and that was why she was left out in the waiting area with staff at the ER waiting desk to monitor patients in the waiting room. When asked several times regarding what options were in place to handle when there are no available beds or free chairs outside the exam rooms other than having patients wait in the waiting room there was no documented system in place. The ER nurse director indicated that other ERs were just as full as theirs, but there was no documented evidence anyone was alerted to check other ERs as an available option at that time nor anything else documented as a plan for whenever the ER was full.	S 138		

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S 138	Continued From page 26 Observation On 12/16/09 at approximately 4pm a tour of the ER revealed cameras in the waiting room. When asked if there was a tape of the night of 11/30/09 when Patient #37 was there, the ER nurse director indicated there was and it was later determined it would be available for review. During the tour in the hallway outside the OBGYN examination room, there were chairs lined up. The ER nurse director indicated that once people in the exam rooms were sent out, the people in the chairs would be able to move into a room. The night Patient #37 presented, the exam rooms and chairs outside the rooms were reportedly full. On 12/17/09 from 1pm through 3:15pm. the non-audible, visual only ER tape of Patient # 37's visit the night of 11/30/09, was reviewed in the security office. From approximately 6:30pm through 11:02 pm Patient #37 and her fiance were observed in the waiting room where the patient was interviewed for vital signs after sign-in and then got registered at the main registration area which was located in close proximity to the security and the ER waiting room desk. During the entire waiting experience Patient #37 was observed at intervals getting up from seat and going to the ER waiting room desk leaning and swaying as if in pain, going to the bathroom, then seated, rocking back and forth at times as if in pain, leaning on fiance, and leaning against the wall. She appears to express discomfort to staff at the sign-in vital signs area as if inquiring about the process and expressing her discomfort.	S 138		

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S 138	Continued From page 27 Emp #1 was observed in the waiting area addressing the waiting room audience and soliciting responses by demonstrating raising their hands at intervals and he would proceed to talk to them where seated. At one point in the tape Emp #1 motions to the fiance and they both are observed walking in the direction of the security officer (SO#1) who was also seen going in the same direction, then the fiance is observed returning to his seat. Another time Emp #1 was seen talking to both Patient #1 and the fiance while seated in the waiting area. Other staff identified by the ER nurse director as Emp #2 was seen doing vital signs initially or checking on patients, and Emp #3 who came in at 7pm to assist in the waiting area. Emp#1 reported by the ER nurse director, who was seen interacting with patients in the waiting area , usually worked in the back but was asked to help up front in the waiting room. During the period of time on tape, observed Patient #37 stood out to be the most demonstrative on tape in appearance of pain. There were a lot of other patients observed on tape, but none who appeared to be visually in as much pain as Patient #37. Also observed were other patients who appeared to be inquiring at the desk as well. The fiance was observed getting up and talking to and gesturing to the staff but not in an aggressive or hostile manner. On several occasions when both fiance and Patient #37 got up, the tape did not show where they went, but appeared to be walking either outside or toward the triage area or to the security desk and then back to their seats until they left. Also there appeared to be dialogue	S 138		

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S 138	Continued From page 28 between the fiance, Patient #37 and some of the others in the waiting room. CPT#24030 Severity:4 Scope:1	S 138		

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